

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|---|--|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155292 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 11/14/2013 | |
| NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00139191. This visit was done in conjunction with a Recertification and State Licensure Survey.</p> <p>Complaint IN00139191- Substantiated. No deficiency related to the allegation(s) is cited.</p> <p>Survey Dates: November 6, 7, 8, 12, 13, & 14, 2013</p> <p>Facility number: 000189 Provider number: 155292 AIM number: 100267330</p> <p>Survey team: Lora Brettnacher, RN-TC Jeanna King, RN Karen Hartman, RN</p> <p>Census bed type: SNF/NF: 141 Residential: 72 Total: 213</p> <p>Census payor type: Medicare: 30 Medicaid: 76 Other: 107 Total: 213</p> <p>Residential sample: 7</p> <p>American Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the Investigation of Complaint IN00139191 and in regard to the Recertification and State Licensure Survey.</p> | | | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155292 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 11/14/2013 |
| NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | Continued From page 1 Quality review completed 11/15/2013 by Brenda Marshall Nunan, R.N. | F 000 | | | |